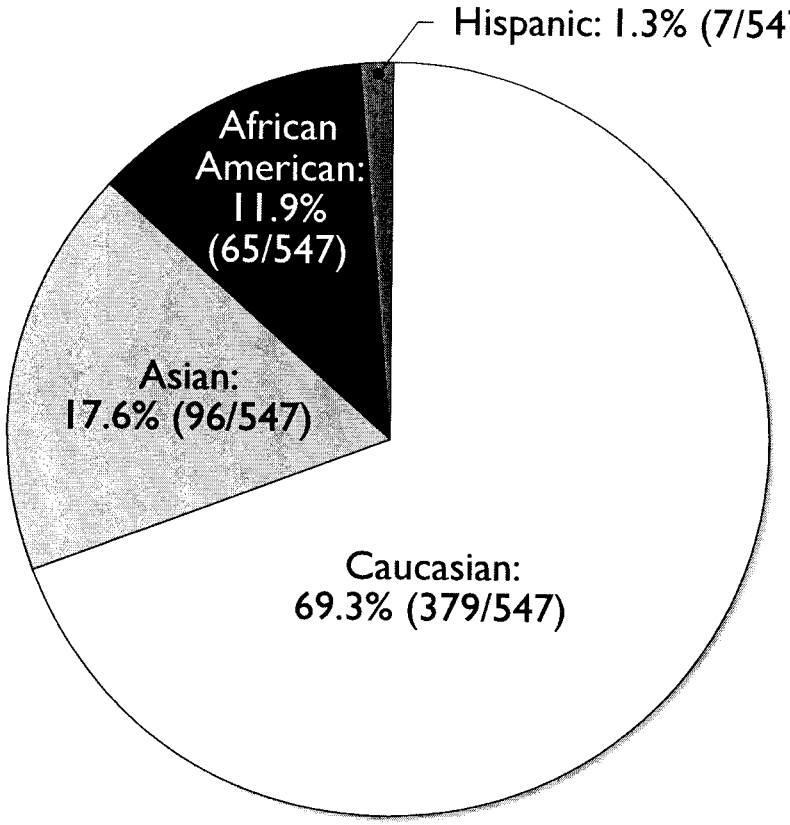
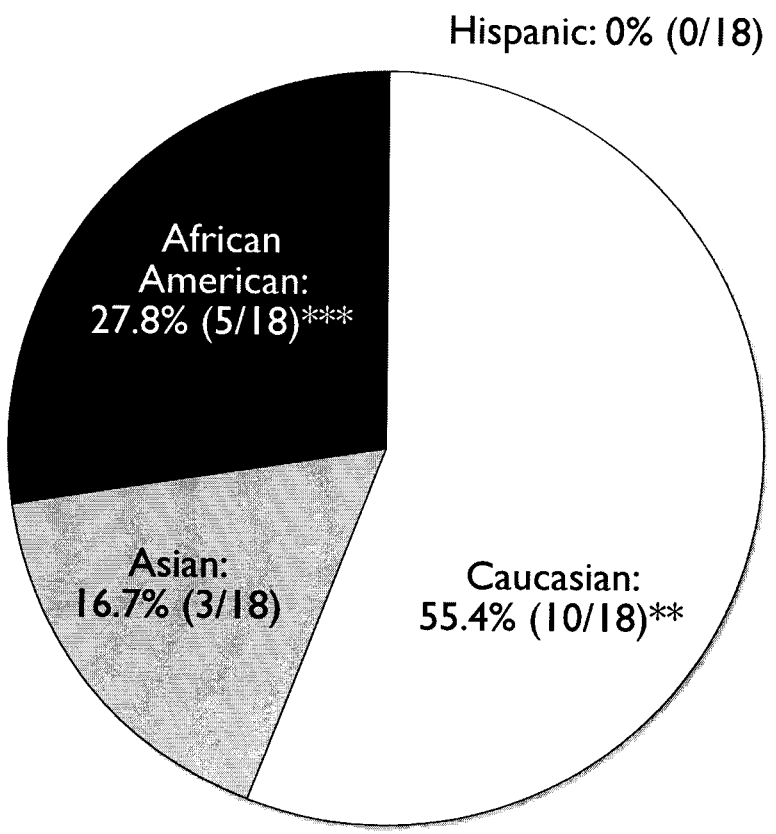
EXHIBIT B

MEC Review

Percentage of Minorities on Medical Staff* vs. Percentage of Minorities Reviewed by MEC



Percentage of Minorities on Medical Staff*



Percentage of Minorities Reviewed

* *There were 991 physicians on medical staff, but ABSMC identified only 547 by race.*

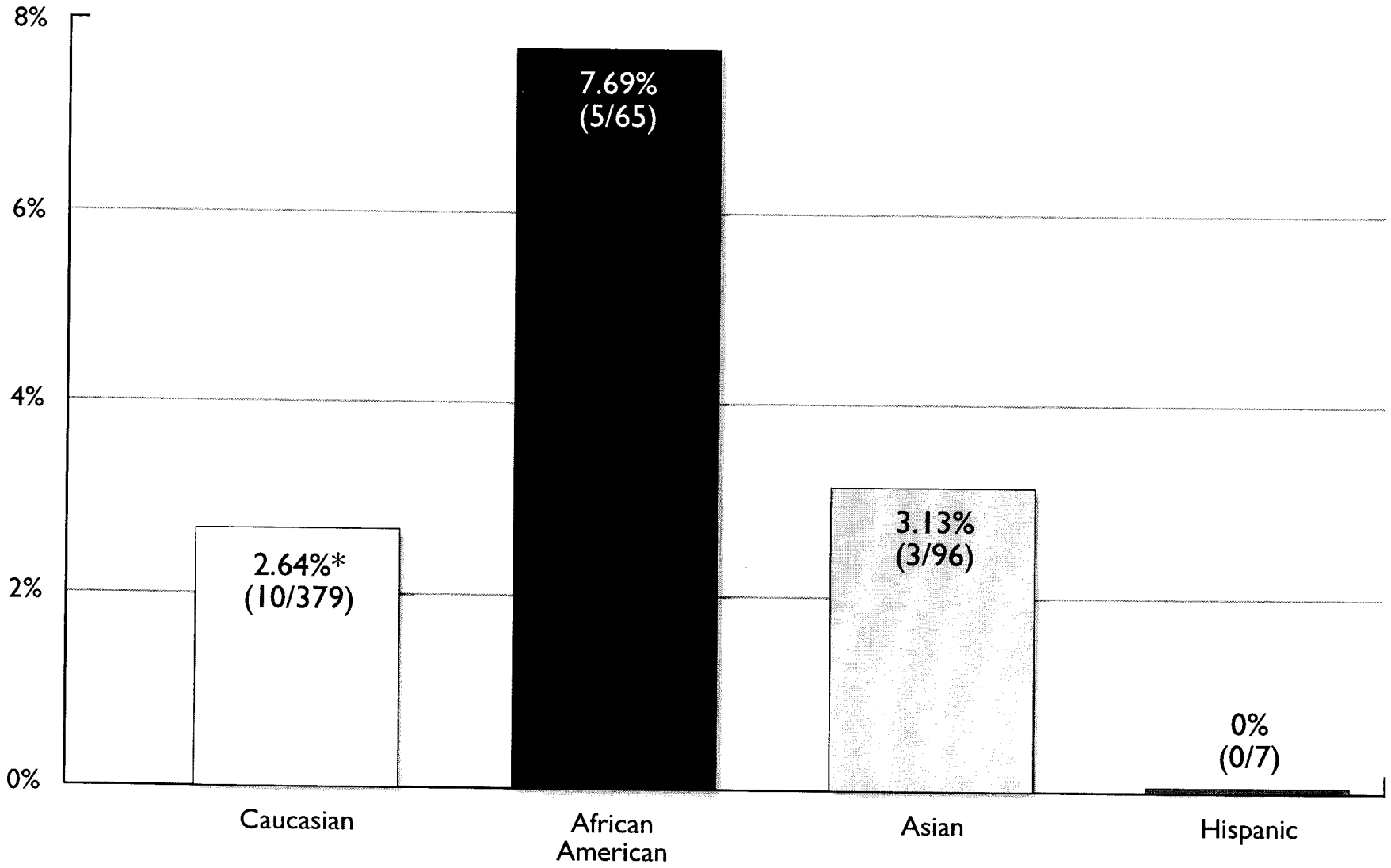
** *One physician, identified by ABSMC as "Physician G," was reviewed twice by the MEC. He is treated here as two separate physicians in order to avoid undercounting MEC review of Caucasians.*

*** *ABSMC stated that the doctor it identified as "Physician H" is "Non African-American." In fact, that doctor's race is a mix of predominantly Indian, African American and Native American. For that reason, he is treated here as African American.*

Case 3:07-cv-02486-WHA Document 167-3 Filed 03/27/2008 Page 2 of 33

EXHIBIT C

MEC Review by Race
As Percentage of Medical Staff

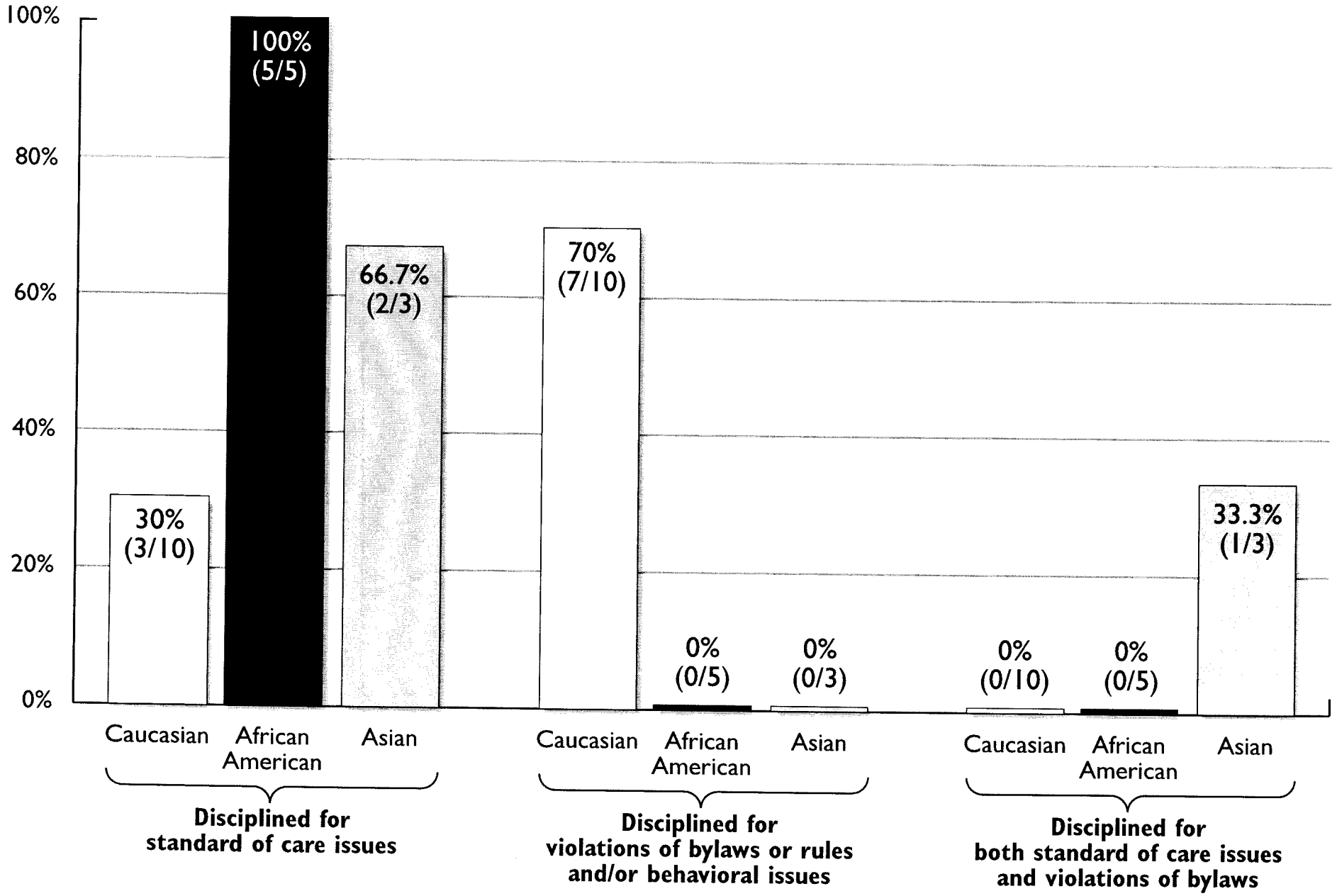


* *One physician, identified by ABSMC as "Physician G," was reviewed twice by the MEC. He is treated here as two separate physicians in order to avoid undercounting MEC review of Caucasians.*

Case 3:07-cv-02486-WHA Document 167-3 Filed 03/27/2008 Page 4 of 33

EXHIBIT D

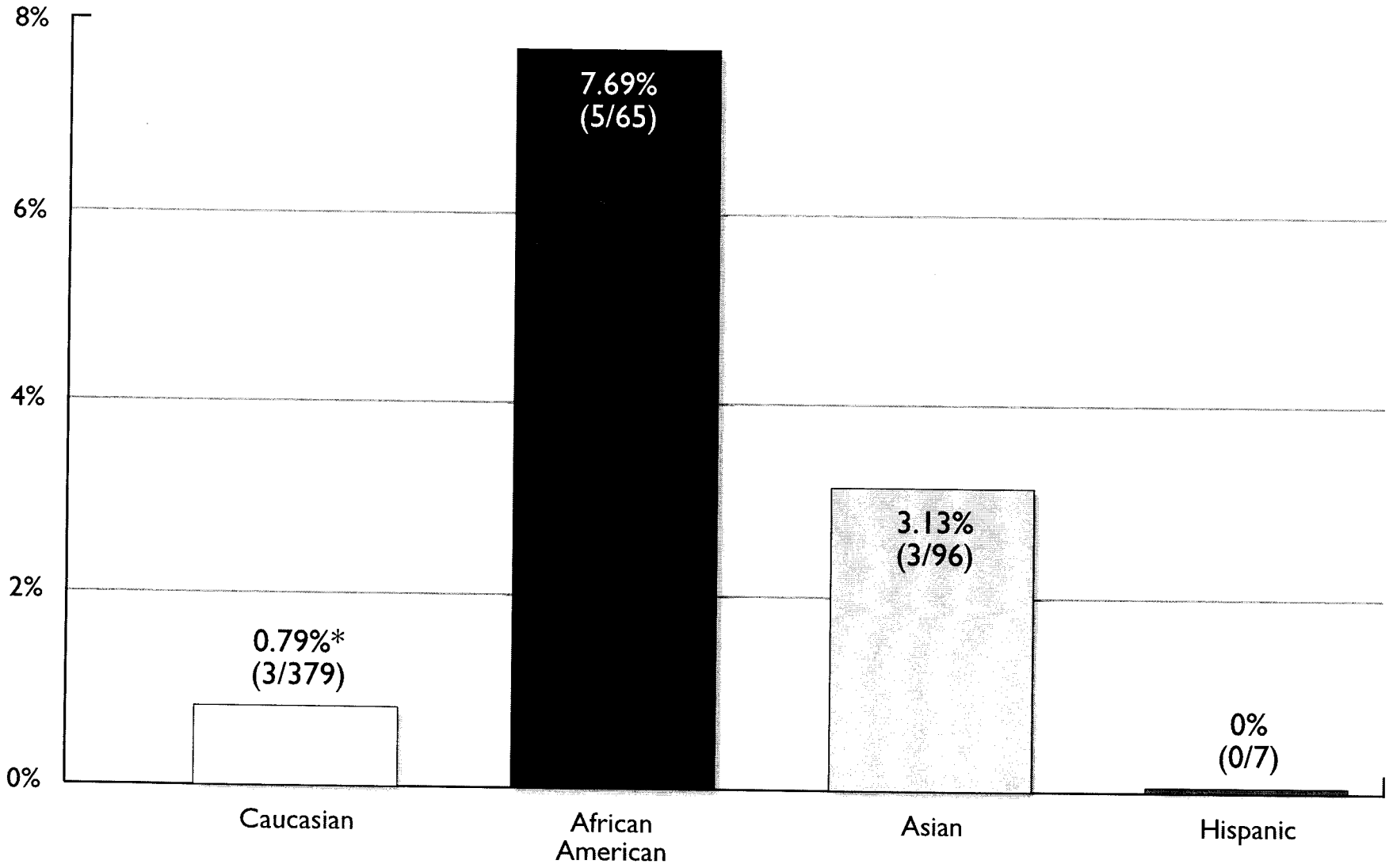
Disciplined ABSMC Physicians, 2004-06
Race Comparison



Case 3:07-cv-02486-WHA Document 167-3 Filed 03/27/2008 Page 6 of 33

EXHIBIT E

MEC Review by Race, for Standard of Care Issues
As Percentage of Medical Staff

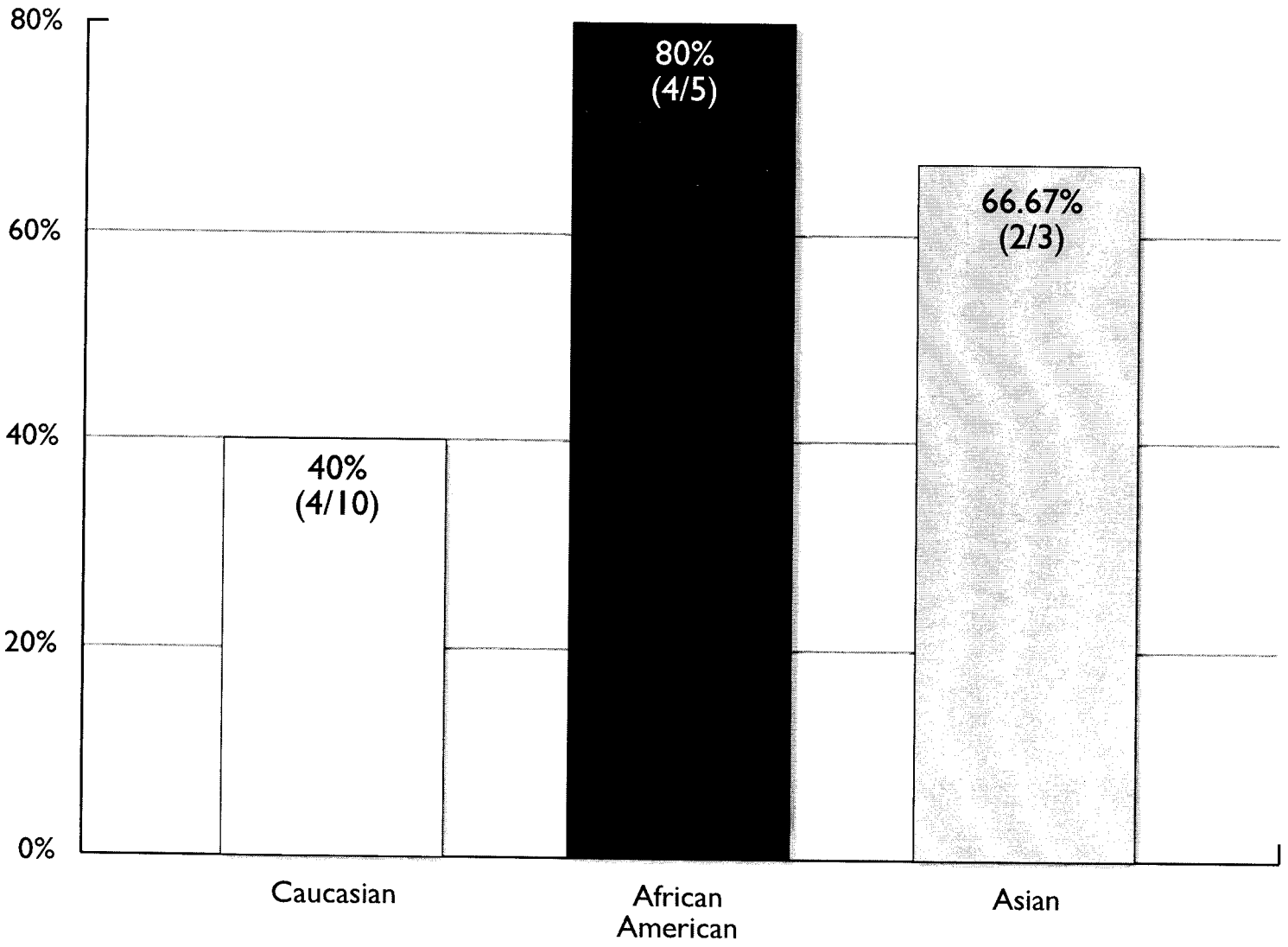


* *One physician, identified by ABSMC as "Physician G," was reviewed twice by the MEC. He is treated here as two separate physicians in order to avoid undercounting MEC review of Caucasians.*

Case 3:07-cv-02486-WHA Document 167-3 Filed 03/27/2008 Page 8 of 33

EXHIBIT F

Summarily Suspended ABSMC Physicians, 2004-06
Race Comparison



Case 3:07-cv-02486-WHA Document 167-3 Filed 03/27/2008 Page 10 of 33

EXHIBIT G

EAST BAY CARDIAC SURGERY CENTER
Medical Group

Specializing in Adult Cardiac Surgery and Thoracic Surgery

Leigh I.G. Iverson, M.D.
Coyness L. Ennix, Jr., M.D.
Russell D. Stanten, M.D.
Junaid H. Khan, M.D.

February13, 2005

CONFIDENTIAL

William Isenberg, M.D., Ph.D
President, Medical Staff
Alta Bates Summit Medical Center
350 Hawthorne Ave.
Oakland, CA. 94609

RE: Peer review of Dr. Coyness L. Ennix, Jr.

Dear Dr. Isenberg:

I was surprised and concerned to learn that an Ad Hoc Committee was sending 10 cases of Dr. Ennix's for an outside review.

I have been associated with Dr. Ennix in a practice of cardiac and thoracic surgery for about 5 years. We have been involved in several hundred cases together. I have known of his excellent reputation for at least 15 years. He is a nationally recognized for his leadership and innovation in cardiac surgery. He has without exception shown outstanding skill and judgment. I've have always respected his insight, technical abilities and judgment. It is my impression that he has been innovative and interested in new ideas and has added significantly to our practice.

I am not familiar with all 10 of the cases involved in this review but I am familiar with the four minimally invasive cases. I believe that after these four cases were peer reviewed by Dr. Hon lee, his review should have been accepted and these four cases closed. I'm not familiar enough with the other six cases to comment. However, in general cardiac surgery in 2005 still has significant risk and complications can occur. It is my understanding that Dr. Ennix's results over the last few years are statistically the same as for the national average when risk adjusted.

In summary, Dr. Ennix is a good surgeon with good judgment and technique. In addition, Dr. Ennix is a gentleman.

Sincerely yours,

Junaid Khan

cc: Steven Stanten, M.D.
Warren Kirk, CEO

3300 Webster Street, Suite 500 Oakland, California 94609-3149 (510) 465-6600 FAX: (510) 839-0806

EXHIBIT H

ATTORNEYS' EYES ONLY

CONFIDENTIAL

SUMMIT MEDICAL CENTER
DEPARTMENT OF SURGERY PEER REVIEW
QUALITY INDICATORS

100% SCREENING

- ***Deaths- Intra-Op and Post-Op (w/in 30 Days of Surgery) and Non-Procedure Death w/ Surgeon as Attending***
  (As of 11/06, it was decided that deaths following incidental tracheostomies would not be reviewed as "Post-Operative Deaths"

- ***Returns to Surgery***
  Excludes dialysis access cases

OTHER CASES BY REFERRAL

- ***Risk Referrals***
- ***Referral from Other Sources*** *(UOFs, Physicians, Other Committees, Critical Care Rounds , etc.)*
- ***JCAHO Monitor Referrals*** *(Blood Usage, Operative and Other Procedure Review, Medication Usage/ ADRs, Medical Records, Documentation, Core Measures)*

*CARDIO-THORACIC SURGERY

Deaths, Complications, Returns to Surgery*: Cases involving cardiac surgery are reviewed by a separate Cardio-Thoracic Peer Review Committee. Physician peer review issues involving questionable sub-standard care/ requiring action are referred to the Surgery Peer Review Committee for follow-up. . Identified system issues are acted upon by that PI Committee (see below).*
CT indicators are also tracked/monitored via STS System (Society of Thoracic Surgery).

Cardiac Surgery has its own Multidisciplinary PI Meeting for identification of opportunities for Performance Improvement. This committee operates under the umbrella of, and its Performance Improvement activities are reported to, the Surgery Peer Review and/or Performance Improvement Committee.

RN CLOSURE CRITERIA

Deaths ** REFER TO MORTALITY REVIEW FLOW CHART

Returns to Surgery **(Note: Dialysis Access cases are not screened)**

- Complication : a) recognized, and b) appropriate interventions taken, c) in a timely manner. No indication of care outside the standard is noted. These cases are "rated" in the MIDAS system.

Revised March, 1998, Surgery Quality
Reviewed/Approved June, 1999, January-02, 2004, February 2007

EXHIBIT NO. 1200
DATE: 1-31-08
WITNESS: MOGG
TOM LANGE, CSR 4689

EXHIBIT I

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COYNESS L. ENNIX, JR., M.D., as an individual and in his representative capacity under Business & Professions Code Section 17200 et seq.,

Plaintiffs,

vs.

No. C 07-2486

RUSSELL D. STANTEN, M.D., LEIGH I.G. IVERSON, M.D., STEVEN A. STANTEN, M.D., WILLIAM M. ISENBERG, M.D., Ph.D., ALTA BATES SUMMIT MEDICAL CENTER and DOES 1 through 100,

Defendants.

_____/

CERTIFIED COPY

CONFIDENTIAL

DESIGNATED "CONFIDENTIAL"
DEPOSITION OF:
MARILYN BARKIN
Thursday, January 24, 2008

Reported by:
DARCY J. BROKAW
RPR, CRR, CLR,
CSR No. 12584

HANNAH KAUFMAN & ASSOCIATES, INC.
Certified Shorthand Reporters
472 Pacheco Street
San Francisco, California 94116

(415)664-4269

Q And how much time did you spend with Mr. Vandall in consultation?

A About four hours, three or four hours.

Q And how much time did you spend going over the documents you've just mentioned?

A Two or three hours.

Q When were you first notified that there was a potential that you would have to testify as what we call the Person Most Knowledgeable on peer review at the departmental division level at Summit?

MR. VANDALL: I'll just object.

He doesn't want to know the contents of any conversations that you and I had. He's just asking you about timing.

BY MR. SWEET:

Q Well, I do want to know the contents of the conversations, but I'm not entitled to them.

But what I am entitled to is to know when you were first notified that you would potentially be testifying as the Person Most Knowledgeable.

A To the best of my recollection, I think it was about ten days ago, a week to ten days ago.

Q Okay. We'll flesh these concepts out a little bit more as we go on here.

But my understanding is that at Summit,

there is a nurse level of review, there is a physician level of review, there then is a cardiothoracic division level of review, and then a surgery division or department level of review; is that accurate?

A Yes.

Q Will you generally tell me -- and again, I'm going to ask you more specifics about this; so I just really want general answers if you can give them -- your role in the nurse, is it quality improvement coordinator --

A Yes.

Q -- level of review.

A I review documents that are provided to me by the organization that help me in identifying cases that would meet the criteria for peer review, meaning deaths, returns to surgery, CVAs and so forth.

Q Ms. Barkin, are you the quality improvement coordinator for the cardiothoracic surgery group?

A Yes.

Q Okay. So there's not more than one?

A No.

Q Okay.

MR. VANDALL: I'm going to object. Ms. Barkin was not finished responding to your question, and you should let her finish her answers before you interrupt her.

BY MR. SWEET:

Q What about -- so you are the quality improvement coordinator for the CT division?

A Yes.

Q What is your role in the -- what I look at as the next level, the physician level of peer review at Summit? And I'm just talking about cardiothoracic cases.

A I understand.

When I identify cases that meet criteria, I prepare a short abstract of the case and refer it -- present that to the reviewing physician for their determination.

Q Okay.

A And I also review the chart and flag the appropriate documents.

Q Meet "criteria" is a word you just used. Is that the same thing as indicators?

A Correct.

Q As the quality improvement coordinator for the CT group or division, do you have it within your

gambit or power to close the case on your own at that point?

MR. VANDALL: Objection; vague.

THE WITNESS: It is in my power. I rarely do that.

BY MR. SWEET:

Q Okay. Sometimes, do you?

A I think I've closed one case over the last year that I felt was -- didn't warrant physician-level review.

Q If I understand -- tell me if this is right or wrong -- the rules and regulations of Summit allow for the quality improvement coordinator to clear the case, don't they?

A Yes, they do.

Q And then you've indicated that once you review a matter as the QIC, you then submit an abstract; is that what you said?

A Correct.

Q What is the abstract called? Does it have a name?

A It's just called the case abstract.

Q Is it a one-page document?

A It can be a lot less than that.

Q What type of information is on the case

until Dr. Iverson retired, whenever that was. It's been over a year. So that would be seven, seven. Except that Kaiser just added an additional surgeon, so it's back up to eight.

Q So it sounds like as a general proposition, there have been eight cardiac surgeons in the cardiothoracic division since 2004?

A Between seven and eight. It varies at times.

Q Can you name them all?

A Yes.

Q Please do so.

A Kaiser was, let's see, David Alyono, A-l-y-o-n-o; Brian Cain, C-a-i-n; Hon, H-o-n, Lee, L-e-e; Dennis Durzinsky, D-u-r-z-i-n-s-k-y.

The Summit group is Russell Stanten; Coyness Ennix; Junaid, J-u-n-a-i-d, Kahn, K-a-h-n; Leigh Iverson; it's L-e-i-g-h, Iverson, I-v-e-r-s-o-n. And the new Kaiser physician who started at the very end of last year is Daniel Pellegrino.

I think that's all.

Q In that group you just listed, is Dr. Ennix the only African-American surgeon?

A Yes.

prior testimony.
BY MR. SWEET:
Q With maybe one exception, correct?
A I try to do all the abstracts on all the cases that meet criteria.
Q Okay. And then it goes -- the matter goes to a physician-level review, correct?
A Correct, yes.
Q Who chooses what physician will participate in a physician-level review?
A The usual -- well, the procedure that's followed is in the cardiothoracic division, if it's one of the Summit cardiothoracic surgeons' cases, it will go to a Kaiser physician for review and vice versa. So if it's a Kaiser physician, it's going to go to a Summit doc for review.
Q Why? Why that procedure?
A To avoid -- to try to keep the process as objective as possible.
Q Whose idea was that, to send Summit matters to Kaiser physicians and vice versa?
A I can't answer that. I don't know.
Q Was that process in place before you assumed the position?
A Yes.

Q Does it remain in place today?
A Yes.
Q Has Dr. Russell Stanten ever suggested that that be changed in any way?
A No.
Q Has anybody --
A Or not to me, he has not suggested it.
Q Has anybody ever suggested that that be changed in any way?
MR. VANDALL: Objection; vague.
THE WITNESS: I'm not aware.
BY MR. SWEET:
Q Who chooses the specific physician that will act as a reviewer?
A For the most part, and -- well, I'm going to say it depends. For the most part, I distribute the cases to the Kaiser physicians based on their availability and who's done the last -- the most the last time. Somebody else is going to get the next batch of cases.
Occasionally, Dr. Stanten will --
Dr. Stanten is aware of all the cases that I'm going to have reviewed either by him or our cases that go to Kaiser. As chief of the department, he's made aware of all the cases that need review, whether

A You know, I believe Dr. Iverson was reviewing them.

Q All of the Kaiser cases?

A I'd be speculating.

Q Okay. Are you saying that you do not make the decision when a Kaiser case needs physician-level review on which Summit physician will review it?

A That would be correct.

Q Why is that, do you know?

MR. VANDALL: Calls for speculation.

THE WITNESS: I don't know. You'd have to ...

BY MR. SWEET:

Q This process, the physician-level review, the Kaiser docs reviewing Summit and vice versa, is that consistent with other peer reviews that you've become aware of in your career, other divisional or departmental peer reviews?

MR. VANDALL: Objection; compound, vague, incomplete hypothetical, lacks foundation.

THE WITNESS: In the sense that physicians who are part of the formal group do not generally review each other's -- do not review a case of another member from their group.

BY MR. SWEET:

Q So that -- I don't want to put words in your mouth, but it sounds standard for the physician-level-review peer review to be handled in the manner that the CT division handles it.

A That would be --

MR. VANDALL: Objection; vague, argumentative and misstates the prior testimony.

BY MR. SWEET:

Q Is that right?

A In order to keep the process objective, you try to find -- well, you find reviewers who are on the committee -- the cases are reviewed by someone who's on the peer review committee. They're not just parsed out to anybody on the medical staff. And physicians who are in the same group do not review each other's cases.

Q Okay. So the answer to my question on whether this process at the Summit CT division, where one group reviews the other group's cases, is a common practice, right?

MR. VANDALL: Objection; vague argumentative, misstates the testimony.

THE WITNESS: Well, I don't know if it's common elsewhere, but, you know -- I don't know

whether it's common or not. That's the way -- what I've told you is the way that it's done in the CT division and by other departments at Summit.

BY MR. SWEET:

Q Like what other departments, if you know?

A Cardiology, for example. There are several different cardiology practice groups.

Q And you were mentioning the reason it's done this way -- and I don't want to put words in your mouth; tell me if this is accurate -- is that's the fair way to do it; is that right?

MR. VANDALL: Objection; misstates prior testimony, argumentative, vague.

THE WITNESS: It would be to make sure that the reviewer could be objective in their review and wouldn't be biased.

BY MR. SWEET:

Q In the CT division, in your experience there since 2004, has that process worked with the physician-level review as you've just described it?

MR. VANDALL: Objection; calls for speculation, calls for a legal conclusion, vague.

BY MR. SWEET:

Q Has it been fair and objective, like it's supposed to be?

A I can't -- I have no way of answering that.

Q Well, do you sit in the cardiothoracic peer review committee meetings?

A Yes, I do.

Q So you have an opportunity to see that process play out, don't you, the peer review process play out?

A With respect to cases that go to the committee level.

Q Okay. Well, back to the physician level, have you -- do you have a concern about the objectivity of the physician-level review in the CT division?

MR. VANDALL: Objection; vague, calls for a personal conclusion. It's outside the scope of this 30(b)(6) deposition.

THE WITNESS: Are you asking me for a personal opinion or -- or whether I think the process is fair?

BY MR. SWEET:

Q As an institution, does Summit believe that that physician-level review, as you've described it, in the CT division is fair?

A I believe they do.

Q Has anybody ever voiced an opinion to you to the contrary, that it's not fair?

MR. VANDALL: Objection; vague, calls for speculation, incomplete hypothetical.

THE WITNESS: No one has voiced an opinion to me.

MR. VANDALL: Do you want to take a two-minute break?

MR. SWEET: That's fine. We've been going an hour. Let's do that. Thank you for the suggestion.

(A brief recess was taken.)

BY MR. SWEET:

Q Ms. Barkin, I want to change gears for just a minute and ask you this question. Each of the physicians at Summit has a physician number; is that right?

A Yes.

Q How are those numbers assigned to the physician?

A I think they come directly out of the system.

Q Are they chronologically assigned? In other words, the doctors who have been there longer have lower numbers than the doctors who have been

BY MR. SWEET:

Q Do you remember the last question?

A No.

Q Okay.

(The record was read back by the reporter as follows:

"Q When a case proceeds from the physician-level review to the cardiothoracic peer review committee level -- I'm sure I'm messing these words up.

"A Come again. What did you just say?

"Q I'm working up the ladder here. We're going from physician level --

"MR. VANDALL: Objection.

"Q -- to cardiothoracic surgery peer review committee level.")

BY MR. SWEET:

Q I want to know the process, after the physician level, of the cases that go to the CT peer review committee.

A So to clarify what you're asking, physician -- a physician-level case gets elevated to

go to the committee, and you're asking --

Q What happens with the case at that point?

A The case comes to the committee, the cardiothoracic peer review committee, and it's discussed. And a determination as to the appropriateness of the care or any concerns is read into the minutes, and the case is either closed or it could be left open for a deferred determination, depending on additional information.

Q How often does the CT surgery peer review committee meet?

MR. VANDALL: Objection; vague as to time.

THE WITNESS: The model is quarterly. Occasionally, those meetings get cancelled or deferred because of scheduling conflicts.

BY MR. SWEET:

Q And are those meetings specifically cardiothoracic surgery peer review committee meetings?

A Yes.

Q And the only thing discussed at those are peer review matters?

A What time frame are you asking about?

Q Well, has it changed over time?

A Yes.

review matters involving CT division members that start at the CT committee level?

MR. VANDALL: Objection; vague, compound.

THE WITNESS: Well, to clarify, the percentage of cases that start at the committee level?

BY MR. SWEET:

Q Yes.

A They generally don't start at the committee level. I mean -- well, at the department -- and I'm only speaking to the CT surgery department level; I'm not speaking to anything higher up. But at my level, a case would generally start at the QIC or the physician reviewer level and then rise.

Q Have you ever heard of a peer review matter starting at the CT division peer review committee level?

MR. VANDALL: Objection; vague.

THE WITNESS: Meaning that it would not have been entered into the database before the committee meeting?

BY MR. SWEET:

Q Because there was no QIC or physician-level review, yes.

A I can't recall that happening. That would be outside of standard operating procedures.

Q And let's talk a little bit more about the CT peer review committee meeting itself.

What do the physicians have available to them to consider when discussing the peer review matters? In other words, do they have the charts there? What do they consider?

A They have the charts.

MR. VANDALL: Objection; vague.

THE WITNESS: I'm sorry.

MR. VANDALL: It's okay.

BY MR. SWEET:

Q They have the charts there?

A They have the chart.

Q Of all of the matters that come to the CT division peer review committee level, all the peer review matters that come there, what percentage of those proceed to the surgery peer review committee?

A During the time that I've been functioning, I don't believe that any cases have gone directly from the CT department, CT peer review committee to the surgery committee.

Q Is it true that -- I'm covering different paths here. But is it true also that no case has

STATE OF CALIFORNIA

I do hereby certify that the witness in the foregoing deposition was by me duly sworn to testify the truth, the whole truth, and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place therein stated; that the testimony of the said witness was reported by me, a Certified Shorthand Reporter and a disinterested person, and was under my supervision thereafter transcribed into typewriting; that thereafter, the witness was given an opportunity to read and correct the deposition transcript, and to subscribe the same; that if unsigned by the witness, the signature has been waived in accordance with stipulation between counsel for the respective parties.

And I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said caption.

IN WITNESS WHEREOF, I have hereunto set my hand the 5th day of February, 2008.

Certified Shorthand Reporter

CSR No. 12584